DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34661

Registration District No. 791 Primary Registration District No. Registrar's No. 9199

1. PLACE OF DEATH: (a) County: St. Louis (b) City or town: St. Louis (If outside city or town limits, write "RURAL" and name of township) (c) Name of hospital or institution: 1525a North 9th Street. (If not in hospital or institution, write street number or location) (d) Length of stay: In hospital or institution: In this community 55 years (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED: (a) State: Missouri (b) County: (c) City or town: St. Louis, (If outside city or town limits, write "RURAL") (d) Street No. 1525a North 9th St. (If rural, give location) (e) If foreign born, how long in U. S. A.? No Physician in Attendance years.

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3. (a) PRINT FULL NAME: Charles Wales 420

3. (b) If veteran, name war: Unknown 3. (c) Social Security No.: Unknown

4. Sex: Male 5. Color or race: White 6. (a) Single, widowed, married, divorced: Single

6. (b) Name of husband or wife: 6. (c) Age of husband or wife if alive: years

7. Birth date of deceased: April 19th, 1864 (Month) (Day) (Year)

8. AGE: Years 75 Months 6 Days 7 If less than one day hr. min.

9. Birthplace: Louiseville (City, town, or county) Kentucky (State or foreign country)

10. Usual occupation: Musical Instrument Repair

11. Industry or business:

FATHER 12. Name: James P. Wales,
13. Birthplace: Unknown (City, town, or county) (State or foreign country)

MOTHER 14. Maiden name: May J. House
15. Birthplace: Unknown (City, town, or county) (State or foreign country)

16. (a) Informant's own signature: Mrs Ora Conners
(b) Address: 1541a Benton Street.

17. (a) Burial (Burial, cremation, or removal) (b) Date thereof: Oct. 30th, 1939 (Month) (Day) (Year)
(c) Place: burial or cremation: Bellefontaine Cem.

18. (a) Signature of funeral director: Aly Leibner Mfg. Co.
(b) Address: 1417 N. Market Street.

19. (a) OCT 27 1939 (Date received local registrar) (b) J. F. Buchek (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month October day 26th year 1939 hour 3:00 minute O. M.

21. I hereby certify that I attended the deceased from ..., 19..., to ..., 19...; that I last saw h... alive on ..., 19...; and that death occurred on the date and hour stated above.

Immediate cause of death: Chronic Hypertrophic Arterio Sclerosis — Duration

Due to:

Due to:

Other conditions (Include pregnancy within 3 months of death):

Major findings: Of operations:

Of autopsy:

PHYSICIAN — Underline the cause to which death should be charged statistically

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify):
(b) Date of occurrence:
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work: (e) Means of injury:

23. Signature: Joseph M. Quinn (M. D. or other)
Address: 1000 Security Bldg. Date signed

(Licensed Embalmer's Statement on Reverse Side)

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important.

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....,

working under my personal supervision.

Signed Homer L. Ponder

Licensed Embalmer No. 3367

P. O. Address 2223 St Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, above space should be left blank.